Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

Carrier's Austin Representative Box
Box Number 45

Respondent Name:
STATE OFFICE OF RISK MANAGEMENT

MDFR Received Date
APRIL 26, 2013

MFDR Tracking Number:
M4-13-2147-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Borck"

Amount in Dispute: $160.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Upon notification of this dispute the Office performed a review of the medical reimbursement request received from [injured employee], which determined that the request for reimbursement that she submitted was reimbursed in accordance with the Division's payment policies in states in Rule §133.270."

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 2012 July 18, 2012	Out of Pocket Expenses – Doctor Visits	$160.00	0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured employees to submit workers' compensation out-of-pocket expenses to the insurance carrier for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - EOBs were not submitted by either party

Issues

1. Did the requestor submit the "Request for Travel Reimbursement"?
2. Did the respondent support the dates of service in dispute have been reimbursed?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Texas Administrative Code §133.270(c) which states, "The insurance carrier shall pay or deny the request for reimbursement within 45 days of the request. Reimbursement shall be made in accordance with §134.1 of this title (relating to Medical Reimbursement)." Review of the documentation submitted by the respondent finds that the dates of service in dispute were paid on August 28, 2012 with Warrant Num: 127549301. The amount of the check was $320.00; payment for dates of service December 9, 2011 in the amount of $80.00 and July 8, 2012 in the amount of $80.00, these dates are not in dispute and April 11, 2012 in the amount of $80.00 and July 18, 2012 in the amount of $80.00, these dates are in dispute.
2. Review of the information submitted by the respondent supports that the injured employee has been reimbursed and no additional reimbursement is ordered.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 10, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.